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TORONTO, June 21 -- Benefits to families from Ontario's medical insurance programme rise as family income increases, says a study released today by the Ontario Economic Council.

The Income Distribution Effect of Medical Insurance in Ontario, by Pranlal Manga, shows that for the lowest income group (under $4,000), where a large proportion of beneficiaries are over 65 years of age, the average yearly benefits per family were $159.31 in 1974-75. The benefits dropped to $145.93 for the next income group ($4,000 to $8,000) then rose progressively to around $254 for those in the $20,000+ income range.

Family size partially accounts for the larger dollar benefits accruing to the higher income groups, but even after adjusting for such differences Mr. Manga's study still shows a slight pro-wealth bias.

Age, sex and education also explain the higher benefits received by higher income groups. For example, females are generally higher users of physician services than males. "The proportion of married females in their fertility years is greatest in the middle and upper income groups, a fact which contributes to the higher average benefits enjoyed by families in those groups," Mr. Manga says.

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Higher income groups use more specialist (and thus more costly) care, whereas the poorer families more often seek medical services from general practitioners.

With the valuable aid of OHIP data, Mr. Manga's work was able to fill in some of the gaps left by earlier studies on utilization and distribution of medical services in Ontario.

An extensive household survey was also incorporated to glean information lacking in OHIP family files, such as family size, income, occupation and education of the head of the family.

The author recommends that a more complete study could be undertaken using information which would integrate OHIP medical records, hospital patient files and certain socioeconomic information presently collected by other federal and provincial agencies.

This study was prepared under the auspices of the Ontario Economic Council, an autonomous research agency funded by the Province of Ontario. The Council acts as an independent advisor on economic issues and undertakes research and policy studies to encourage the optimum development of the human and material resources of Ontario and supports the advancement of all the sectors of the Province. The Council achieves these goals by sponsorship of research projects, publication of studies, and organization of the Outlook and Issues conferences and seminars which are open to the public.

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NOTE: A list of persons to contact for further information, a brief biographical sketch of the author and a selection of quotations from the study are attached.

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FOR FURTHER INFORMATION CONTACT:

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AUTHOR'S BIOGRAPHICAL SKETCH:

Mr. Manga is a National Health Research Scholar at the School of Health Administration, University of Ottawa. He earned a B.A. and M.A. (Economics) from McMaster University, and a Ph.D (Economics) from the University of Toronto. He has worked in various positions in government on health and welfare and has served with the Treasury Board and the Anti-Inflation Board. Mr. Manga has also been a Senior Research Officer (Health) at the Ontario Economic Council.

The Income Distribution Effect of Medical Insurance in Ontario, by Pranlal Manga, is available only at the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario M7A 1N8. Price. 3.00. A cheque or money order, payable to the Treasurer of Ontario must accompany all mail orders.

OTHER RESEARCH REPORTS prepared for the Ontario Economic Council can be obtained from the University of Toronto Press, 5201 Dufferin Street, Downsview, Ontario M3H 5T8; at major booksellers; or from the Ontario Government Bookstore at the address above.

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SELECTED QUOTATIONS:

"There are significant variations in the average dollar benefits and physician services received by OHIP families from the medical insurance program in Ontario. Excluding the lowest income class, there is a distinct positive relationship between family medical benefits and family income. Estimates presented in chapter 4 show the following average family benefits by income class: $159.31 ($0 - 3,999), $145.93 ($4,000 - 7,999), $202.07 ($8,000 - 13,999), $257.01 ($14,00 - 19,999) and $253.69 ($20,000+). The global average family benefits for the sample population were $215.94. Chapters 4 and 5 showed that the observed pro-rich bias in the distribution of medical benefits can be explained by a number of sociodemographic variables, such as the average size of the OHIP families and their age and sex composition. The observed distribution of benefits is also due partly to differences in the average cost of services received by persons in different income classes." (Pg. 139)

"The analysis in this chapter shows that the distribution of medical benefits depends upon how the population unit of analysis (the OHIP family) is defined. If families are grouped only by incomes, which is common in most incidence studies, the results show significantly higher average medical benefits to the higher-income families than to the lower-income families. When the OHIP family is standardized in terms of demographic factors a more even distribution of medical benefits by income class is evident. If further adjustment is made for differences in other socioeconomic factors that might explain the variation in the family medical benefits, further benefit incidence estimates can be derived." (Pg. 135)

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"Indeed, for the population generally, the cost per physician encounter and/or service increases with income class. The higher income groups tend to have a greater volume of specialist encounters and services than other income classes. The poorest families receive a significantly greater proportion of their physician services in hospitals than do other income groups. There appears to be a positive relationship between physician services and income class for services rendered in physicians' offices." (Pg. 140)

"This analysis of public medical and hospital insurance programs estimated gross benefits, not net benefits. No attempt has been made to consider the costs (through premiums and taxes) to the various population groups. As discussed in chapter 1, to do so would have involved a balanced budget incidence analysis." (Pg. 141)

"Equity viewed simply in terms of income-size class may not be an issue, at least not one as significant as equity defined other ways. For instance, what matters may be the distribution of benefits according to the health care needs of the population, and we saw, on the basis of a very crude proxy indicator of health status, that those with greater needs do receive significantly greater medical benefits." (Pg. 143)

"Two preliminary steps seem necessary before a simulation study can be most profitable. First, the three microdata files should be merged on a person-by-person basis, so that for each person in the sample the entire set of independent variables and utilization variables are merged. An analysis of the utilization or benefits can then be performed per capita rather than per family, or per person per family. A person-by-person microdata file allows a less complicated, more flexible, and more meaningful specification in multivariate analysis of such variables as age, sex and health status. The second preliminary step concerns health status information." (Pg. 146)

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"This OHIP file allows a number of immediately apparent improvements over the survey vehicle. ... But there are two major problems in using OHIP medical data. First, and most important, OHIP medical files do not have all the data required for the study. For example, the files do not have data on family size (they register only those who receive services), nor the data on family income (without which an incidence study is not possible), education and occupation of the head of the family or spouse, and other relevant socioeconomic variables. Basically, OHIP data identify the beneficiary unit only by the OHIP insurance number and the age and sex of the patient. The second problem, a technical matter of retrieval, is that the utilization information from the OHIP files is readily accessible only via the OHIP insurance numbers. Thus, while the OHIP records are the best utilization data available, they are still grossly incomplete." (Pg. 45)